Gracewell Healthcare 1 Limited

Gracewell of Frome

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 17 and 18 July 2018. The first day of the inspection was carried out by one adult social care inspector, a Pharmacy inspector, a specialist nurse advisor and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector and a specialist nurse advisor and was announced.

Gracewell of Frome is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service has a dual registration which means there are two registered providers jointly managing the regulated activities at this single location. They are: Gracewell Healthcare Limited and Gracewell Healthcare 3 Limited. This means the service is subject to one inspection visit however the report is published on our website twice, under each provider.

This was the first inspection since the location was registered with the new dual provider Gracewell Healthcare 3 Limited. No concerns were identified during the registration process.

People told us they felt safe living in the home. One person said, "Yes I feel very safe, because there is always someone here to look after me."

There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. All staff spoken with were confident action would be taken by the registered manager and provider to address any issues they may raise.

There were sufficient staff to meet the needs of people in the home and a recruitment programme meant they no longer needed to rely on support from agency staff. However, some staff and relatives felt there could be more staff on duty at busy times. The management team had listened to people's comments and a twilight shift had been introduced.

The administration of medicines was managed safely however it was noted that a there was some excess stocks of medicines in the home and some people had missed medicines due to stock not being replaced. The deputy manager said they were currently looking into these shortfalls and discussing with their suppliers.

People received effective care from staff who were well trained and understood their needs, likes and dislikes. However, we recommended the provider looked at ways of using the knowledge and expertise of local healthcare professionals to support training for qualified staff.

People told us the dining experience was outstanding we observed most people were supported to eat and drink with dignity and respect. The home chef had developed sensory meals for people which involved them using all their senses to enjoy a meal using reminiscence of smells and sounds. Meals for people who required pureed diets were well presented with the food still resembling its original shape through moulding and sculpting. The chef told us about the smoothie's recipes they had adapted for people in the home. This meant they could liaise with GP's when fortified foods were required so that people could have fortified smoothies of their choice rather than prescribed fortified drinks.

People said they received care and support from caring and kind staff. Comments included, "They [the staff] are all really nice and they care about me." And, "They [the staff] are all lovely. They have a tough job and always do it with a smile."

People told us they could talk with staff and the manager if they wished to raise a concern. One person said, "He [the manager] is always visible and takes the time to listen. If I felt the need to complain, which I don't. I think he would listen to me."

People received care that was responsive to their needs and personalised to their wishes because regular staff knew their likes, dislikes and needs. aspects of their day to day lives. An activities programme was displayed within the home and people were informed of the activities available to them. People told us there was a full activities programme with plenty to do. The memory floor specifically had areas that promoted reminiscence and the use of a sensory table was available for people to use and interact with. People were asked about their dreams and goals so staff could look at ways to make their "dreams come true." For example, one person wanted a bird of prey to sit on their arm and staff had arranged for this to happen. There were strong links with local community groups who were actively encouraged to be involved with the home.

People were supported at the end of their life to have a comfortable pain free death. Care plans showed people's advance decisions were taken into consideration and acted upon.

There were formal and informal quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care.

The management team had a clear understanding of the management of the home and how to lead staff by example. They and the provider were committed to continuously improving the service. This was apparent when staff spoke about the future of the home in the local community. Incentives were introduced to reward staff for going above and beyond what was expected of them and staff were actively involved in community fund raising to raise the profile of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who had been recruited to make sure they were safe to work with vulnerable people.

There were sufficient staff to maintain people's safety and meet their needs. Recruitment had ensured consistency of regular staff to meet people's needs.

People's medicines were safely administered by staff who had received appropriate training to carry out the task. However, some people had missed medicines due to lack of stock.

Is the service effective?

Good

The service was effective.

People's health and well-being was monitored by staff and advice and guidance was sought from healthcare professionals to meet some specific needs.

People had access to a nutritional diet and food was provided which met their specific needs and wishes.

People received care with their consent or in their best interests if they were unable to give full consent.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and patient.

People's privacy and dignity were respected and they received support in a way that respected their choices.

Is the service responsive?

Good

The service was responsive.

People could take part in organised activities or choose to

occupy their time in their preferred way. A full activity programme included community involvement and reminiscence.

Care plans were person centred and informative however, the electronic system was not being used to its full potential.

People could make choices about their day to day lives.

People said they would be comfortable to speak with a member of staff if they had any complaints about their care or support.

Is the service well-led?

Good

The service was well led.

The management team promoted inclusion and encouraged an open working environment.

Staff received feedback from the management and felt recognised for their work.

Quality monitoring systems were in place which ensured the management had a good oversight of service delivery

The home was led by a management team that was approachable and respected by the people, relatives and staff.

The home was continuously working to learn, improve and measure the delivery of care to people.

Gracewell of Frome

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 and 18 July 2018. The first day of the inspection was carried out by one adult social care inspector, a Pharmacy inspector, a specialist nurse advisor and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector and a specialist nurse advisor and was announced.

This was the first inspection since the location was registered with the new dual provider Gracewell Healthcare 3 Limited. No concerns were identified during the registration process.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During this inspection we spoke with 10 people living at the home, 10 members of staff and six visiting relatives. We also spoke with the deputy manager and the regional manager. We spent time observing care practices in communal areas of the home.

We looked at a number of records relating to individual care and the running of the home. These included seven care and support plans, three staff personnel files, training and supervision records and minutes of meetings held at the home.

Good

Is the service safe?

Our findings

People received care that was safe and protected them from harm. People told us they felt safe living in Gracewell of Frome. One person said, "I feel safe, I get on with all the staff and feel I could talk to the manager if I ever I had a problem." Another person said, "I feel safe because people are around all the time, I'm never on my own, as I was at home, and I'm close to my family." Visiting relatives told us that they felt their family members were safe. One relative said, "My [family member] is so safe, and always looks good whenever I come in at any time of the day. Always clean and well cared for. I can go away with complete confidence and absolutely no worries, knowing that they'd [staff] call me if there was a problem." Another relative said, "The staff are attentive, and very good with [the person]. I feel [the person] is absolutely safe here. I'm in three to four times a week so I'd see if anything wasn't right."

During our inspection we looked at the systems in place to manage medicines. Medicines were stored securely and access was restricted to appropriate individuals. Room and fridge temperatures were recorded daily to ensure medicines were kept at suitable temperatures. There was excess stock of some medicines and the provider was working with the supplying pharmacy and GP surgery to reduce this. However, we did find some out of date medicines kept in the stock cupboards. There were suitable arrangements for storing and recording medicines that required extra security.

Staff administering medicines undertook regular training and competency assessments. When medicines were given they were recorded on Medication Administration Records (MARs). Handwritten MARs had been signed, dated and double signed to make sure they were correct. At the end of each medicines round staff reviewed the MARs to ensure that there were no gaps in the recording. A medication profile was available for each person and this explained how they liked to take their medicines. Allergies had been printed on the MAR charts but after comparing to the medication profiles, a couple of records were not consistent. The service has since addressed these discrepancies. We reviewed 14 MARs and saw that people were given their medicines in the way prescribed for them. Specific arrangements were made for medicines which had to be administered at a certain time, so these were given correctly. However, five people had missed doses of their medicines as they were not in stock. The provider has since completed an investigation into this and developed an action plan.

Risk assessments were completed for people who wanted to manage their own medicines to make sure it was safe for them to do so.

Protocols for medicines which are to be taken "when required" were available. Some lacked person specific details on when medicines should be given. However, when we spoke with staff it was clear they knew exactly when these medicines should be administered.

The provider had systems and processes which helped to minimise risks of abuse to people. These included a robust recruitment process and ensuring staff understood how to recognise and report concerns.

Before commencing work all new staff were thoroughly checked to make sure they were suitable to work for

the organisation. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. One staff member confirmed they had not started work until all the relevant checks had been carried out, they told us, "They waited for my references and criminal records check before I could start so that was good."

The staff we spoke with had completed training about how to recognise and report abuse and all were confident that anything reported within the home would be dealt with to make sure people were safe. One member of staff said, "I would never worry about raising concerns if I had any worries and I am confident they would be taken seriously and dealt with." Another staff member was able to tell us who they could talk to outside of the organisation if they felt they needed to.

Systems were in place to identify and reduce the risks to people living in the home. People's care plans included risk assessments however some care plans lacked clear guidelines. For example one person at risk of pressure ulcers did not have a record for the correct setting of their pressure mattress. We discussed this with the deputy manager who said they would look at it straight away. Staff had contacted appropriate professionals to make sure people at risk of developing pressure ulcers had suitable pressure relieving equipment in place.

Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. We saw evidence of other risk assessments relating to, nutrition and hydration and the risk of falls. When people needed transferring there were clear guidelines about which type of sling and hoist should be used. One person told us about their experience of being hoisted to change their position they said, "They know what they're doing, in relation to the body and its movement, they do it all very well".

There were conflicting comments on the staffing levels in the home. All the staff spoken with said they could do with more staff, One staff member said, we are so busy some days we do not get a break until 12o'clock then lunch at 4 o'clock." Another staff member said, "I think things are improving it was a bit disorganised last month with too many staff being granted annual leave at the same time so we have had to cover extra shifts. [The new manager] has worked hard to sort it out so I think things are improving."

People living in the home and their families expressed satisfaction with the way staff responded to call bells, although some said there were occasional waits. One person said, "I think there are enough staff, I rarely wait very long for my bell to be answered." One relative explained how they had complained to the manager about the length of time their family member waited for their bell to be answered. They told us, "I've been meeting with the manager to follow up about [the person] waiting a long time, and have looked at the audit records. About 80% of the calls seem to be answered within a few minutes, most within five minutes, but a few have waited around 20 minutes." Relatives visiting the home said they felt the times when staffing was an issue was when reception staff were not at front of house. They found that telephone calls took a long time to be answered and if visiting in the evening staff took a long time to answer the front door. The provider had analysed the call bell audits and noted what people and their families had said about evenings to solve this they had introduced a twilight shift to support staff in the evenings.

The deputy manager explained that there were sufficient staff in the home according to their dependency scores however staff had not always been deployed effectively. To assist with this all staff in the home assisted at mealtimes and the twilight shift had been introduced. They told us they had looked at linking the front door bell with the call bell system so staff on all floors would know a visitor was waiting to be let in. This showed that the provider had listened to the comments made by staff people and their families and taken action. We observed at lunch time that there were sufficient staff assisting people. This meant the

meal time was unrushed and people were supported in a timely manner.

People were protected against the risks of the spread of infection because all areas of the home were kept clean. There were handwashing facilities throughout the home and alcohol gel was available for staff and visitors to use. There was clear guidance in toilets on hand washing and staff had received infection control training. Staff had access to personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and safety and fire safety.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

There was a system in place to record any accidents or incidents that occurred. These would be reported directly to the registered manager so appropriate action could be taken. The time and place of any accident/incident was analysed to establish any trends or patterns and monitor if changes to practice needed to be made.

Good

Is the service effective?

Our findings

People received care and support from staff who had the skills and knowledge to meet their needs. People said that staff knew their needs and preferences, and expressed confidence in their ability to support them. One person said, "The staff understand me and they know what they're doing. I've never had any problems in getting the care I need. If I'm not well the staff look after me more closely, and will get the doctor in to see me." One person said how they would like to know more about staff roles. They told us, "The staff are always helpful, they seem to know what they're doing, I get the care I need. I'm not sure about their training or what they're supposed to do though. It would help to know more about their roles and what's expected of them. A booklet perhaps to tell you what each person is supposed to do."

People told us the provision of nutritious, healthy diets was outstanding. The deputy manager explained how they had found specialist anti shaking cutlery for people with Parkinson's so they could continue to be independent. They had also decided as an organisation to use a specialised milk, which is 'naturally enriched'. Audits had shown that since using this milk they [the organisation] had seen a reduction in infections and an increased health and wellbeing in people living in the home. People experienced themed evenings sampling food from around the world. The chef told us about an Indian evening when they had used the smells of spices in the home to boost people's appetites. The first Sunday of the month was put aside as a Sunday Carvery.

Everybody spoke highly about the food served in the home. People told us, "The food is really quite good, there's enough of it and you get a choice. We get plenty to eat and drink, tea or water and soft drinks whenever you want." And, "The food is like a hotel. It's amazing, the choice, the quantity and the range, it's marvellous." And. "The food is ok, not as good as home cooked food but it's alright and there's enough choice. You can always ask for other things if you need them." Two relatives told us, "The food is excellent. I use any excuse to have a meal here. The chef was a finalist in a national competition. You can book to have a meal with your loved one downstairs, where the tables are beautifully laid, or you can have coffee, tea, cake or order something from the Bistro menu." And, "We have eaten here, the food is very good."

The home chef had been a finalist in national competition with their sensory meals. These are meals that involve all the senses and are exceptionally good for people with visual impairments. The specialist advisor experienced a sensory meal and said it was an excellent experience and they felt they were really at the sea side with their fish and chips. The chef told us about plans to introduce smells such as fresh coffee or fresh baked bread to encourage people's appetites. The chef had also attended a course on how to present softened diets in an appetising way with pureed meals being sculpted to look like the food they really were. The chef also told us about the smoothie's recipes they had adapted for people in the home. This meant they could liaise with GP's when fortified foods were required so that people could have fortified smoothies of their choice rather than prescribed fortified drinks.

The chef explained that they had a corporate menu which was reviewed seasonally but the home could adapt this to the choices of people in the home. They would have a monthly meeting with people in the home to find out what they wanted and how they wanted things cooked and presented. They also had diet

cards in the kitchen which reminded kitchen staff of people's dietary needs likes and dislikes. They told us, "I never say no to a resident. If they want it I will go and get it, I recently went to [local supermarket] and got some smoked salmon for a resident as that was all they wanted. It is their choice after all."

We observed mealtimes in the home and saw people were supported with dignity and respect. However, the experience was different for people on each floor. For example, on one floor we observed there were five staff members to 17 people, which meant people received their food in a timely manner. We saw two people being supported with eating. Staff sat with the people when they supported them to eat and explained what the meal was and when they were helping them. The mealtime occasion was relaxed with people enjoying a chat and socialising with other people or their relatives. In the memory care unit, we saw staff did not always seek consent in all their interactions with people. For example, we heard a staff member say; "I'll just put this on you," as they put a napkin on someone's lap, rather than explaining what they wanted to do and asking for permission first. We also saw staff taking plates away without asking people if they had finished, and checking with them if it was alright to do so. Staff didn't always ask for permission to help with eating and drinking. We heard one staff member say, "I'll just pour this drink for you," rather than, "Would you like me to pour your drink?"

There were kitchen areas on each floor for people and their families to access drinks and snacks independently. There were cold drinks dispensers in the communal areas which we saw people using. One person said, "I like to be able to just go and get a drink myself and this is a good idea."

All new staff worked a probationary period and carried out a full induction including the providers mandatory training. The induction included information relating to the Care Certificate and gave new staff the chance to shadow more experienced staff. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. Staff confirmed they had spent time in induction training and shadowing other staff before working unsupervised.

Staff received the training they required to safely fulfil their roles and effectively support people. However, there were mixed opinions from staff about the training provided at the home. One staff member told us the training was excellent and they had attended all they needed to. They confirmed they had also attended training specific to people's needs and told us they had especially liked the dementia awareness training. However, another staff member said the training was good but was "not on a level playing field." They told us, "I was told the training would mean we were able to progress through the organisation by becoming a senior carer but that doesn't seem to happen. Not everybody has been offered the dementia training and that would benefit everybody." Records showed that staff had attended and received updates in the areas the provider considered mandatory training. On a noticeboard in the reception area it stated, "The things we do that are outstanding. Staff supervisions 98%. 97% Training compliance."

The provider also supported registered nurses to maintain their registration through continued personal development. Trained staff confirmed the provider supported them to keep up to date with their skills and personal development. However, when we asked about the input of diabetic, respiratory and heart failure nurses, the nurses we spoke with said they did not access them for advice or practice development.

We recommend the provider looks at ways of accessing healthcare professionals for advice and practice development.

The provider had a training matrix which showed when staff had completed training and when updates

were required. This helped to make sure people received care and support from staff who had up to date skills and knowledge to meet their needs.

Staff confirmed they received support from the manager to discuss people's care needs and their training needs. Staff attended regular one to one supervision with senior staff and an annual appraisal. They also attended team meetings when wider issues could be discussed. For example, one staff meeting had identified the low uptake of the online training and emphasised the need for staff to keep up to date with changing practices.

Staff worked with other professionals to make sure people received the care and treatment they needed. A registered nurse was always on duty with care staff to ensure people's nursing needs were monitored and met. People told us they had good access to healthcare professionals according to their individual needs. One person told us, "I can see the doctor when I want to or need to." Care records showed people had access to a range of professionals to promote their health and well-being such as GPs, nurses, opticians and dieticians.

People only received care and support with their consent or in their best interests if they were unable to give consent. We heard staff asking people if they wished to be helped and staff respected their decisions. Care plans we looked at showed people's ability to make specific decisions had been assessed. Records showed how the staff had tried to involve people as far as possible in decision making. People told us they felt they maintained control over their care, one person said, "They [staff] always ask me if it's alright to come in or do this or that, they're very respectful and polite". Another person said, "They're very respectful indeed and always ask permission. They offer me a shower, a bath or a wash, and I prefer to have a wash, so that's what they give me every day". Relatives also confirmed staff sought people's consent however one relative said, "They always ask [the person] first, but I think they [staff] could be more persuasive. They ask [the person] if they'd like to attend an activity or have a bath, and if the answer is no they leave it at that. They [the staff] say [the person] refuses but we'd like to see more gentle persuasion."

Staff had received training about the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff spoken with were aware of the need to assess people's capacity to make specific decisions. Where appropriate they had involved family and professional representatives to ensure decisions made were in people's best interests. Care plans contained assessments of people's capacity to make certain decisions and where necessary, a best interest meeting was held with appropriate people involved in their care and decision making.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made when necessary and the registered manager had followed up decisions with the local authority. When a DoLS application was accepted the registered manager completed the necessary notification to CQC.

The memory care unit had been suitably adapted to help people maintain their independence and take part in meaningful activities. Each person's room had a memory box outside the door as a prompt to remind

them it was their room. The boxes were personalised to everyone with specific items that had a personal meaning for that person. Areas of the home had been decorated to have some meaning to people. For example, there were colour contrast walls and multiple items of interesting memorabilia on display to encourage reminiscence, and provide 'rummaging' or sensory stimulation, including a haberdashery counter, a dressing table, and an
interactive touch screen table, this has a series of interactive light games specifically designed for people living with dementia. During the inspection a cot and nursery equipment were delivered to provide a nursery area.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the day we saw staff spoke to people respectfully and showed kindness and patience when supporting them. Staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

People spoke positively about their relationships with staff, although two people said they didn't see much of staff outside of care giving. People told us, "I like the staff, they're all very kind and I get on with them, we have a laugh." And "The staff listen to you, that's the main thing, they're kind and caring." And "The staff are very pleasant, but I hardly see them unless I want something. Very few people come in, they don't come to chat."

Relatives spoke positively about staff relationships with their family members. They told us, "The staff are all very nice, attentive and friendly. The hostesses are very good and get on well with [the person] and always have a chat." And "The staff are lovely and very friendly and [the person] seems happy here." And "The staff are very good; the receptionist is excellent and you know if you give [person's name] a message it will get through. There's always a nice happy atmosphere."

People's privacy and dignity were respected and their independence was promoted where possible. One person said, "They're very good with that [privacy and respect]. They knock on the door, and when I'm having a wash they keep me covered up and don't expose me to the world." Another person said, "You're able to be in your room undisturbed. The staff won't come in without permission and they always knock and wait till you call back to them".

Each person's room had a door knocker and people could choose to have a name plate if they wished on their door. We observed doors remained closed during care giving and witnessed staff knocking on doors before entering. One person had an additional framed sign on their door which said, "Can I ask that my front door remains closed." This showed staff respected individual requests for privacy. People were able to choose who supported them with personal care. This was clearly recorded in people's care plans. Staff told us of people who preferred female care workers and they all knew to ensure this was respected.

Some people we spoke with were not sure about being involved in creating their care plans. One person could recall discussing their care plan and said it was well organised with their views being taken into consideration. Relatives spoken with told us they had been involved and had been given the chance to comment on the way care was provided. One visiting relative said, "I've been involved in the care plan. We have regular reviews, actually I've had an email to book a time to come in and go through it and check and personalise the plan." Another relative said, "We had a review when [the person] moved up to the first floor and because they can't walk now. So, it's all up to date." However, one relative told us they had instigated the reviews they had been to, they said, "We've never been invited to a review, the meetings we've had have been at our request; to go through the care plan and check that [the person] is getting the right care."

Good

Is the service responsive?

Our findings

Staff were responsive to people's needs and wishes. They had a very clear understanding of people's needs and how to meet them. People told us they were happy with the care and support they received. One person said, "It's very good here, I get everything I need and there's nothing to improve. I'm quite happy." A visiting relative said, "It's absolutely excellent. The care is exemplary. The staff are very good quality and the really know what [the person] needs and likes."

The provider had introduced a computerised care planning system. People's care plans were entered onto the system and care staff could record interactions in real time. This meant that there were clear records of when people had eaten and how much, and when people had been repositioned. However, the system was not being used to its full potential. Staff were still coming to terms with the best way to use the system to maximise the positive impacts on people's care and support.

There were some inconsistencies in the recording of the care provided and omissions relating to equipment checking and detailing the changes to resident's care. For example, one care plan did not identify when specific procedures had been carried out. There was clear guidance for staff on the maintenance of equipment to support one person to receive nutritional supplements through a tube (PEG), there was an advance rotate chart, PEG syringe change day sheet and a feeding machine cleaning chart. The care plan showed these had all be signed as completed however there was no evidence of the PEG site itself being reviewed, the state of the skin, and if there had ever been any issues.

Regular reviews of care plans were carried out however the computerised system did not appear to evaluate the care provided in a structured and clear way. Evidence of reviews was available however it was identified by a computer-generated statement which did not show what had been considered during the process. This was also looked at during care plan audits and the deputy manager told us they had already identified some areas where staff were not using the computerised system effectively and had arranged further training and group supervisions to improve the input and used of the system. Staff were very positive in using the system and said they liked being able to put information in as it happened.

Care plans showed that there was a person-centred approach to identifying people's wishes, likes and dislikes. One person told us how staff were very good at respecting people's likes and dislikes they said, "I like to be up at 5.30 in the morning, I am always ready and the staff all respect my wishes and come and help me when I call." Another person told us, "They [staff] ask me if I want a shower or a bath and they help me to pick out my clothes, and that sort of thing. I'm able to do what I want to do really."

Staff were responsive to people's changing needs. For example, they had input from the Parkinson's specialist nurse who reviewed the person's medication at least every six months. One staff member told us how one person came into the home bed bound and since being in the home had been able to sit out in a chair due to the person's response to medication management.

The home had developed a good working relationship with the local GP practices. They used two practices

which were both based in the local medical centre. There was a weekly GP round every Monday which was followed up by a visit by the nurse practitioner who would pick up any clinical reviews that were outstanding. The home was working closely with the GP to introduce Treatment Escalation Plans which clearly document people's and when appropriate family wishes relating to resuscitation status.

People could be confident that at the end of their lives they would be treated with compassion and any discomfort would be effectively managed. People were supported to make choices about the care they received at the end of their life. The staff worked closely with local healthcare professionals to ensure people's comfort and dignity at the end of their lives was maintained. People's care plans included advance decisions. The document was person centred and included details on what was important to the person and their loved ones. This included where the person would prefer to be cared for if their condition deteriorated. We saw staff were gradually introducing the new document and where including people's wishes in their care plan as they discussed them with people and their families.

Staff worked alongside a multidisciplinary team such as the local hospice where they accessed training to ensure staff could meet people's needs. The manager and community nursing staff ensured appropriate medicines were available to people nearing the end of their life to manage their pain and promote their dignity. One relative told us how they had been involved with their loved one and staff in agreeing the person's end of life wishes in their care plans.

It was clear that the provider has invested significantly in the purchase of specialist equipment for people with memory loss and the emphasis on activities being used extensively daily could be seen on the first floor. They had also appointed a memory care specialist who worked with people to ensure that care was person centred. People and their relatives told us that the activities in the home were, "Excellent." One person said, "There are things going on all the time. Sometimes I go but you have the choice. I prefer it when my family come and we go outside." Another person said, "I love it when the little ones [pre-school group] come in, it's lovely." Whilst a third person said, "I join in the activities. Sometimes I make myself do it as you could get very withdrawn if you just stayed in your room. Most of the entertainment is very good and some less so, but there's a good variety." One relative said, "We'd like [the person] to start getting involved with activities, and want to talk to staff about that. They [the person] needs encouraging and doesn't realise what's involved."

The care home explored many innovative and inclusive aspects of care, particularly around caring for people with memory loss. They ensured that people's wishes were considered to enhance the quality of their life. For example, people were asked about any goals and 'dreams' they had. One person had stated they wanted to "Have a bird of prey sit on their arm." On the second day of the inspection a bird of prey handler arrived and people sat in the garden whilst they demonstrated what they could do. They then arranged for the person to hold and fly the bird. Staff had also looked at other people's dreams such as flying in an aeroplane and were looking at ways of "making the dreams come true." One person enjoyed feeding the birds but had overfed the pigeons so staff bought them a pair of budgerigars for Christmas. The person was happy to show us their pets.

We spoke with the activities organisers about their role in the home. They told us they spoke to people about the activities they wanted to take part in and tried to make sure they were meaningful to the people in the home. People had benefited from regular visits from a local pre-school, trips out, a visit from the local army cadets for VE day and the local scouts to do their badges. They also joined the local allotment club opposite the home who had put in seating and paths for people to watch them working. One relative said, "I'm involved in organising a mini festival here, providing classical music and poetry recitals. They have 'seated dance' up on the 2nd floor which has been successful and [their family member] is responding. They

also have one to one time, and the activities team and volunteers spend time with those who need that."

The activities organisers explained that they generally worked Monday to Friday and were in the process of developing memory boxes for each person on the memory floor. This meant staff would be able to sit down with the person and talk about something meaningful with them that they found in the box. They were involving people and their relatives to make sure the boxes were meaningful and useful.

One relative told us how the home was involved with the local community, they said, "There's a bus and sometimes they arrange outings, and they also take people to the allotment where they can join in with gardening. The preschool and school groups come in and sing or spend time with the residents" Another relative had arranged for a Rock choir to visit whilst people had enjoyed a cheese and wine evening, book club and trips to local museums and garden centres.

The home had a complaints procedure which was prominently displayed and was routinely given to people when they moved in. We looked at the complaints procedure and found it was written in large print so people with a visual impairment would be able to access the policy.

People and visitors said they would be comfortable to make a complaint if they were unhappy with any aspect of their care. Most people said they would speak to the manager or the deputy. One person said, "I've never had to complain, but if I needed to I'd certainly feel able to and to start with I'd talk to the 'sister' in charge." Another person said, "I've never made a complaint, there's been no need, and I'm the sort of person who would." One relative said, "The only thing I've raised is about the windows. I'm sure [the manager] is fed up with me mentioning them would like them to open wider but I know they must comply with health and safety. They have been good at responding."

We discussed with the staff how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff told us they used a variety of ways to communicate information depending on the person. We observed staff showing a person both options for lunch so they could choose. Other information could also be provided in either; easy read versions, large print or verbally recorded. At the time of the inspection everybody's first language was English, however translations of documents could be obtained for people whose first language was not English.

Good

Is the service well-led?

Our findings

People benefitted from a service that was well led. There was still a registered manager however they had been promoted to operations manager and a new manager was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the new manager was away so the deputy and regional managers were present.

People, relatives and staff told us the new manager had an open and transparent approach to managing the home. Staff told us the new manager was ready to listen and act on suggestions. One staff member said, "The new manager is a steady rock, he is a calm people person. Very open and approachable. We also have clinical support and a very strong team ethic."

People told us they felt the home was well led. One person told us, "The managers are very accessible." Another person said, "I see the manager about, they take time to listen to me." Relatives told us they had seen positive changes in the management of the home, one relative said, "The new manager has just taken over, he's approachable and visible. [Former manager's name] was excellent, always here working hard even at weekends. They made the changes which you can see now." Another relative said, "[Former manager's name] had achieved a real change of culture which is very difficult to do." However, some relatives felt the changeover of managers had not been carried out in an open and transparent way. Two relatives said, "It was unclear for a while who was in charge and there was an interim manager. There's been a lack of transparency from the company, and it wasn't a good thing to move both manager and deputy at the same time." And, "One thing was that they didn't really announce the changes, for a while it was up in the air, but now it's more settled."

People and their relatives or people important to them were involved and engaged with by staff and the management team. One relative said, "Communication has improved. I am kept informed of meetings and events." Regular resident/relative meetings were held when people could express their views and have an impact on how the home was run. One relative said, "The resident/family meetings are regular and they hold them at 2.30 pm and 6.30pm, so there's no excuse not to come to one of the times. they do the minutes and send them out to everyone." The deputy manager explained how they also had a resident representative who had been involved with staff recruitment and bringing people views to meetings when they could not attend. We did not speak to the resident representative as they had been unwell.

The management team displayed a, "you said we did" approach to listening to people in the entrance area. This showed that people's requests had been listened to and acted on. We saw responses to requests such as, "You said, we would like independent access from 2nd floor to reception. We have put door guards in place and a doorbell to reception." And "People requested better recycling in the home so recycling bins had been provided for each unit." Other action taken included seating outside the front of the home and an improved bathing experience with new bathes installed for people with mobility needs.

The management team were building up a working relationship with the local community. One staff member told us how they had worked within the community to raise the home profile. They had met with healthcare professionals to make them aware of what they could and could not provide. They had also built up relationships with the local community such as the allotment group, local Alzheimer's society, Frome widows group and the stroke club. Representatives of the home would attend their meetings or coffee mornings to let them know what Gracewell could provide for the local community. Staff also took part in local fundraising events. The staff member said, "Everybody has worked really hard to build up our profile, the nicest bit is when you get positive feedback from the community. I love my Job."

Systems in place were being used effectively to identify and drive improvements in the home. Issues raised had been managed through training for staff and team managers. For example, the home chef had attended training in how to ensure people who had a pureed diet received food that was presented in an appetising way. This meant they could still represent the type of pureed food on people's plates through sculpting and moulding the food to look like the original item.

There were effective quality assurance systems operated by the manager deputy manager and operational manager. These included regular audits, themed conversations with people and staff. Looking at areas to improve and mange excellence within the home. To ensure the care provided for people was consistent and met their needs, senior management completed audits of topics including medicine administration, night care and care plan reviews. In addition, they completed weekly and daily checks, such as reviewing nutrition, hydration and re-positioning records, and ensured medical equipment was fully functioning.

We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, the management team had looked at staffing, staff incentives and recruitment. This meant the home had not used agency staff for some time ensuring a more consistent approach to care and support in the home. The deputy manager had identified that staff were not using the electronic care planning system to its full potential so staff training and group supervision was put in place to address this specific shortfall.

The management team and provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. A copy of the homes policy and procedure for the Duty of Candour was available for people, staff and visitors to read. This demonstrated the organisations approach to being open and transparent.

Staff confirmed that a system of one to one supervision meant they could discuss training needs and any issues regarding the care and support they provided or the running of the home. This also gave the registered manager the opportunity to share best practice training and guidelines with staff either on a personal basis or in group supervision. Staff were also rewarded for going above and beyond what was expected of them. For example, the organisation ran, "The Hearts and Souls Awards," when staff were recognised for the good work they had done.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The management team attended local provider groups which enabled them to keep up to date with local initiatives and share good practice with their own staff and other providers. The management team also kept their skills and knowledge up to date, through research and training, and through manager meetings within the organisation when they could share what went well and what they did about things that did not

go so well.

The registered provider ensured the home was run in line with current legislation and good practice guidelines. There were up to date policies that were available to all staff to make sure they had the information they required to provide safe and effective care.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.